Spondyloarthritis: NICE Releases Guidelines on Diagnosis and Treatment

Key Points for Practice

- Spondyloarthritis should not be ruled out based only on negative laboratory results from HLA-B27, C-reactive protein measurement, or erythrocyte sedimentation rate testing.
- All patients diagnosed with axial spondyloarthritis should be referred to a subspecialist for a structured exercise program.
- First-line pharmacologic treatment for axial spondyloarthritis is the lowest effective dose of a nonsteroidal anti-inflammatory drug with continued evaluation and monitoring.

From the AFP *Editors*

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Spondyloarthritis comprises inflammatory disorders that have some overlapping characteristics. Most persons with spondyloarthritis present with psoriatic arthritis or axial spondyloarthritis, including ankylosing spondylitis. Less common presentations include enteropathic spondyloarthritis, which is related to inflammatory bowel disease, and reactive arthritis, which occurs in persons after a gastrointestinal or genitourinary infection. Psoriatic arthritis has a varied presentation and can occur in small hand and foot joints, large joints such as the knee, or axial joints. Axial spondyloarthritis and ankylosing spondylitis typically occur in the spine. Lastly, there is undifferentiated spondyloarthritis, which usually occurs in fewer than five joints, but typically includes the knees.

Ankylosing spondylitis and nonradiographic axial spondyloarthritis are considered predominantly axial, whereas psoriatic arthritis, reactive arthritis, and enteropathic arthritis are considered predominantly peripheral, although features may overlap. The signs and symptoms of spondyloarthritis often go unrecognized, delaying diagnosis and treatment and increasing the risk of progression of the condition and possible disability. For this reason, the National Institute for Health and Care Excellence (NICE) released a guideline on diagnosing and treating spondyloarthritis.

Recommendations

DIAGNOSIS

Spondyloarthritis cannot be ruled out based on a single symptom or test result. Symptoms can include musculoskeletal problems (e.g., inflammatory back pain, enthesitis) or extra-articular issues (e.g., uveitis, psoriasis), with family history and recent genitourinary infection considered risk factors. Axial spondyloarthritis occurs equally in men and women, can be found in persons who are negative for human leukocyte antigen B27 (HLA-B27), and is possible even in persons without sacroiliitis on radiography.

TESTING

Spondyloarthritis should not be ruled out based only on a negative result on an HLA-B27 test or a normal C-reactive protein measurement or erythrocyte sedimentation rate. If the patient has a positive result on HLA-B27 testing, the likelihood of peripheral spondyloarthritis is increased. Infective antibody testing should not be routinely performed to confirm reactive arthritis in persons who have had a gastrointestinal infection.

IMAGING

Axial Spondyloarthritis. Radiography should be discussed with persons who may have axial spondyloarthritis, assuming they have a mature skeleton. If sacroiliitis found on radiography meets the modified New York criteria, then the diagnosis can be confirmed. If the criteria are not met or radiography cannot be performed because of an immature skeleton, magnetic resonance imaging (MRI) can be performed. A follow-up MRI is an option when diagnosis

cannot be confirmed, but there is still a high suspicion. Scintigraphy should not be performed.

Peripheral Spondyloarthritis. Radiography of the hands and feet should be discussed with patients. If it is performed and cannot confirm the diagnosis, ultrasonography can be considered. If peripheral spondyloarthritis is diagnosed, radiography of the sacroiliac joints should be considered to evaluate for axial involvement.

TREATMENT

Axial Spondyloarthritis. All patients with axial spondyloarthritis should be referred to a subspecialist for a structured exercise program. First-line pharmacologic treatment is the lowest effective dose of a nonsteroidal anti-inflammatory drug (NSAID) with continued evaluation and monitoring. If the NSAID is not effective after two to four weeks, another NSAID can be tried. The addition of hydrotherapy for pain or referral to a subspecialist for difficulties with daily activities can be considered.

Peripheral Spondyloarthritis. First-line treatment options include corticosteroid injections for nonprogressive monoarthritis, and standard disease-modifying antirheumatic drugs (DMARDs) can be used for peripheral polyarthritis, oligoarthritis, and persistent monoarthritis. NSAIDs can be added to DMARDs at the lowest effective dose, with continued evaluation and monitoring. Injection and oral corticosteroids in the short term can be added instead of NSAIDs if the NSAIDs are ineffective. For psoriatic arthritis, if the standard DMARD is ineffective at the highest tolerable dose for three months, adding or using a different standard DMARD can be considered. As with axial spondyloarthritis, referral to a subspecialist for difficulties with daily activities can be considered.

REFERRAL

Axial Spondyloarthritis. Referral to a rheumatologist should be made for patients suspected of having axial spondyloarthritis who have had back pain since before 45 years of age that has lasted more than three months if they also have at least four of the following criteria: back pain occurring before 35 years of age; waking at night to alleviate symptoms; buttock pain; improved pain when moving or within two days of taking an NSAID; a first-degree family member with spondyloarthritis; or current or previous arthritis, enthesitis, or psoriasis. The patient should still be referred if only three of these criteria are met and an HLA-B27 test is positive.

Peripheral Spondyloarthritis. All persons presenting with dactylitis should be referred to a rheumatologist. In addition, persons with enthesitis without a clear etiology should be referred if it is persistent or in multiple areas; the patient has a family history of spondyloarthritis or psoriasis; or there is back pain without an etiology, current or past uveitis or psoriasis, gastrointestinal or genitourinary infection, or inflammatory bowel disease.

Acute Anterior Uveitis. Immediate referral to an ophthalmologist is warranted in those presenting with symptoms of uveitis, including eye pain or redness.

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Available at: https://www.nice.org.uk/guidance/ng65/evidence/full-guideline-pdf-4368823741

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